		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025940

Facility Name: Mercy Health Care Rehab Center

Address: 19000 South Halsted (Number) Homewood (City) 60430-4299 (Zip Code)

County: Cook

Telephone Number: (708) 957-9200 **Fax #** (708) 957-7828

IDPA ID Number: 369093232001

Date of Initial License for Current Owners: 12/10/80

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael Kaplan **Telephone Number:** (312) 634-3400
Please send copies of any desk review or audit adjustments to the address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/00 to 6/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,535	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,587	194	2,288	11,069	8
9	SNF/PED					9
10	ICF	56,305	2,498	45	58,848	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,892	2,692	2,333	69,917	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.96%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/10/80

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 12/10/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 37 and days of care provided 1,985

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	[X]	MODIFIED CASH*	[ ]	CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments** 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	360,641	39,501	12,461	412,603		412,603		412,603			1
2	Food Purchase		302,520		302,520		302,520	(5,938)	296,582			2
3	Housekeeping	311,990	38,989		350,979		350,979		350,979			3
4	Laundry	153,504	74,143		227,647		227,647		227,647			4
5	Heat and Other Utilities			195,640	195,640		195,640		195,640			5
6	Maintenance	116,532	11,897	21,389	149,818		149,818		149,818			6
7	Other (specify):*											7
8	**TOTAL General Services**	942,667	467,050	229,490	1,639,207		1,639,207	(5,938)	1,633,269			8
	B. Health Care and Programs											
9	Medical Director			53,333	53,333		53,333		53,333			9
10	Nursing and Medical Records	2,400,499	164,510	824,754	3,389,763		3,389,763		3,389,763			10
10a	Therapy	89,931	1,321	872	92,124		92,124		92,124			10a
11	Activities	83,619	4,595	2,983	91,197		91,197		91,197			11
12	Social Services	71,530	1,066		72,596		72,596		72,596			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,645,579	171,492	881,942	3,699,013		3,699,013		3,699,013			16
	C. General Administration											
17	Administrative	138,549			138,549		138,549		138,549			17
18	Directors Fees											18
19	Professional Services			148,265	148,265		148,265	(8,801)	139,464			19
20	Dues, Fees, Subscriptions & Promotions			14,377	14,377		14,377	(1,090)	13,287			20
21	Clerical & General Office Expenses	275,357	15,189	51,939	342,485		342,485	(10,192)	332,293			21
22	Employee Benefits & Payroll Taxes			831,179	831,179		831,179		831,179			22
23	Inservice Training & Education			846	846		846		846			23
24	Travel and Seminar			1,706	1,706		1,706		1,706			24
25	Other Admin. Staff Transportation			3,577	3,577		3,577		3,577			25
26	Insurance-Prop.Liab.Malpractice			128,944	128,944		128,944		128,944			26
27	Other (specify):*											27
28	**TOTAL General Administration**	413,906	15,189	1,180,833	1,609,928		1,609,928	(20,083)	1,589,845			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,002,152	653,731	2,292,265	6,948,148		6,948,148	(26,021)	6,922,127			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mercy Health Care Rehab Center #0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments**	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			204,983	204,983		204,983	5,410	210,393			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			386,242	386,242		386,242	(74,441)	311,801			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,848	15,848		15,848		15,848			35
36	Other (specify):*											36
37	**TOTAL Ownership**			607,073	607,073		607,073	(69,031)	538,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,155	9,565	57,720		57,720		57,720			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):* Nonallowable costs			35,844	35,844		35,844	(35,844)				43
44	**TOTAL Special Cost Centers**		48,155	187,212	235,367		235,367	(35,844)	199,523			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,002,152	701,886	3,086,550	7,790,588		7,790,588	(130,896)	7,659,692			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,619)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,410	30		9
10	Interest and Other Investment Income	(74,441)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,971)	43		24
25	Fund Raising, Advertising and Promotional	(995)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,733)	43		28
29	Other-Attach Schedule See Schedule 5A	(39,547)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (130,896)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,896)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MERCY HEALTH CARE AND REHABILITATION CENTER
FACILITY ID # 00025940
6/30/2001

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Nonallowable chamber of commerce dues	(1,090)	20
Nonallowable OSHA penalty	(700)	43
Nonallowable marketing salaries	(10,106)	21
Nonallowable legal fees (out of period)	(8,801)	19
Nonallowable collection fees	(15,467)	43
Nonallowable candy cart and raffle	119	43
Gifts	(84)	43
Nonallowable Resident Clothing	(13)	43
Vending Machine Income	(3,319)	2
Miscellaneous Income	(86)	21
Total Nonallowable Expenses	(39,547)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Mercy Health Care Rehab Center

ID# 0025940

Report Period Beginning: 7/01/00

Ending: 6/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 **Report Period Beginning:** 7/01/00 **Ending:** 6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,619)	0	0	0	0	0	0	0	0	0	0	(2,619)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,619)	0	0	0	0	0	0	0	0	0	0	(2,619)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,619)	0	0	0	0	0	0	0	0	0	0	(2,619)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Mercy Health Care Rehab Center** **#** **0025940** **Report Period Beginning:** **7/01/00** **Ending:** **6/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,410	0	0	0	0	0	0	0	0	0	0	5,410	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(74,441)	0	0	0	0	0	0	0	0	0	0	(74,441)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(69,031)	0	0	0	0	0	0	0	0	0	0	(69,031)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(19,699)	0	0	0	0	0	0	0	0	0	0	(19,699)	43
44	**TOTAL Special Cost Centers**	(19,699)	0	0	0	0	0	0	0	0	0	0	(19,699)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(91,349)	0	0	0	0	0	0	0	0	0	0	(91,349)	45

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A				Mercy Hospital	Chicago	Hospital
		N/A				
See attached Schedule 6A for board of directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V			N/A						2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Mercy Health Care and Rehabilitation Center
Facility #00025940
June 30, 2001

Medicaid Cost Report
Schedule 6A

Page 6: VII - Schedule A - Non-Profit required attachment: List of Board of Directors

Board Member	Directly Provided Services	Type of Service	Entity owned by Board Member doing Business with nursing home	Type of Business Conducted
Robert O'Leary	No	N/A	N/A	N/A
Brenda Finnegan	No	N/A	N/A	N/A
Gavin Weir	No	N/A	N/A	N/A
John T Doody	No	N/A	N/A	N/A
Janice Podwika	No	N/A	N/A	N/A
Dominick Velo	No	N/A	N/A	N/A
William Frank	No	N/A	N/A	N/A
Nancy Swanson	No	N/A	N/A	N/A
Andrew Ross	No	N/A	N/A	N/A
Subhash Shah	No	N/A	N/A	N/A
Gertrude Cernock	No	N/A	N/A	N/A
Ann Flanagan	No	N/A	N/A	N/A
Sheila Lyne	No	N/A	N/A	N/A
Michael T. Ryan	No	N/A	N/A	N/A
Conleth Foley	No	N/A	N/A	N/A
	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL. Health Facilities Auth.		X	Mortgage	$54,128.00	11/17/92	$ 6,700,000	$ 5,240,000	01/10/15	0.0570	$ 372,610	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$54,128.00		$ 6,700,000	$ 5,240,000			$ 372,610	9
	B. Non-Facility Related*											
10	Amortization of Loan Cost										13,632	10
11	Offset Interest Income										(74,441)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (60,809)	14
15	TOTALS (line 9+line14)						$ 6,700,000	$ 5,240,000			$ 311,801	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Health Care Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025940

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,542 B. General Construction Type: Exterior Brick Frame Block Number of Stories 3

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	313,600	1980	$ 327,507	1
2					2
3	TOTALS	313,600		$ 327,507	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		1980	1980	$ 4,362,591	$ 77,845	35	$ 77,845	$	$ 3,234,458	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1981	92,067		15	175	175	86,654	9
10	Various			1982	11,489	281	15	281		11,065	10
11	Various			1983	3,584	108	15	108		3,433	11
12	Various			1984	57,218	526	15	526		55,807	12
13	Various			1985	75,390	2,130	15	2,130		71,935	13
14	Various			1986	15,476	819	15	819		6,306	14
15	Various			1987	24,676		10	1,234	1,234	6,170	15
16	Various			1988	25,646		10	1,282	1,282	7,654	16
17	Various			1989	7,928		10			7,928	17
18	Various			1990	28,912	1,078	10	1,078		28,912	18
19	Various			1991	158,994	13,076	10	13,076		153,868	19
20	Various			1992	600	60	10	60		510	20
21	Various			1993	195,646	5,556	39	5,150	(406)	40,046	21
22	Various			1994	1,067,096	27,179	39	27,488	309	193,280	22
23	Various			1995	114,903	2,545	20	5,746	3,201	29,254	23
24	Dining Room Remodel			1995	2,400	62	20	120	58	669	24
25	Condensing Unit			1995	542	27	20	27		189	25
26	Condensing Unit			1995	1,083	54	20	54		378	26
27	Repair Boiler			1995	1,954	50	20	98	48	540	27
28	Balances In Window			1995	1,142	29	20	57	28	315	28
29	Replaced Boiler			1995	2,290	59	20	114	55	628	29
30	Wallpaper			1995	4,206	108	20	210	102	1,143	30
31	Dedication Wall			1995	1,355	35	20	68	33	363	31
32	Floor & Wall Coverings			1995	12,860	330	20	643	313	3,440	32
33	Wall Border & Coverings			1995	1,929	49	20	96	47	515	33
34	Message Board			1995	872	22	20	44	22	233	34
35	Sign			1995	434		20	22	22	123	35
36	Water Manifolds			1996	900	23	20	45	22	237	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remove Wall & Repair	1996	$ 5,122	$ 131	20	$ 256	$ 125	$ 1,315	37
38	Dining Room Remodeling	1996	4,073	104	20	204	100	1,167	38
39	Control Board & Light	1996	1,088	28	20	54	26	275	39
40	Remodeling	1996	3,674	525	20	184	(341)	1,789	40
41	Generator	1996	19,620	3,924	10		(3,924)	19,620	41
42	Engine Generator	1996	8,285	1,657	10		(1,657)	8,285	42
43	Dining Room Remodeling	1996	4,436	114	20	222	108	1,112	43
44	Pavilion Remodeling	1996	6,751	173	20	338	165	1,676	44
45	Shades	1996	1,079	216	20	72	(144)	1,043	45
46	Pavilion Remodeling	1996	7,053	181	20	181		890	46
47	Hot Water Boiler	1997	11,960	307	20	598	291	2,676	47
48	Emergency Generator	1997	1,640	42	20	82	40	390	48
49	Pavilion Remodeling	1997	1,121	29	20	56	27	265	49
50	Building Rewiring	1997	2,994	77	20	150	73	699	50
51	Rewiring	1997	3,087	79	20	154	75	684	51
52	Rewiring	1997	359	9	20	18	9	78	52
53	Carpeting	1997	1,365	35	20	68	33	302	53
54	Accusensors	1997	841	22	20	42	20	181	54
55	Peipe-Dryers	1998	3,547	91	20	177	86	756	55
56	Sheetmetal	1998	835	21	20	42	21	178	56
57	Electric Work	1998	4,171	107	20	209	102	889	57
58	Sliding Door	1999	13,951	1,395	20	1,395		3,297	58
59	Railing	1999	2,190	219	20	219		383	59
60	Door Protection	1999	190	19	20	19		33	60
61	Concrete Pad	1999	2,400	62	20	120	58	171	61
62	Lighting	1999	79,475	2,038	20	3,974	1,936	6,954	62
63	Partitions	2000	2,000	200	20	200		200	63
64	General Contracting	2000	3,240	324	20	324		351	64
65	Flooring	2000	10,923	280	20	546	266	616	65
66	Concrete Pad	2000	1,550	155	20	155		168	66
67	Roof	2000	2,747	275	20	275		343	67
68	Elevator Conversion	2000	19,884	510	20	510		510	68
69	Concrete Pillars	2000	6,100	104	20	104		104	69
70	TOTAL (lines 4 thru 69)		$ 6,511,934	$ 145,504		$ 149,544	$ 4,040	$ 4,003,453	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,511,934	$ 145,504		$ 149,544	$ 4,040	$ 4,003,453	1
2	Wall Covering	2001	6,005	51	20	51		51	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,517,939	$ 145,555		$ 149,595	$ 4,040	$ 4,003,504	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 462,330	$ 49,516	$ 50,886	$ 1,370	5-10yrs	$ 328,600	71
72	Current Year Purchases	25,486	1,900	1,900		5-10yrs.	1,900	72
73	Fully Depreciated Assets	1,172,548					1,172,548	73
74								74
75	TOTALS	$ 1,660,364	$ 51,416	$ 52,786	$ 1,370		$ 1,503,048	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	95 Cadillac Eldorado	1994	$ 40,058	$ 8,012	$ 8,012	$	5	$ 32,214	76
77										77
78										78
79										79
80	TOTALS			$ 40,058	$ 8,012	$ 8,012	$		$ 32,214	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,545,868	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 204,983	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,393	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,410	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,538,766	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 15,848 Description: Beds $6,645, Postage Meter $516, & Photocopier $8,687
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10a, C 1&2	1494 hrs	$ 52,691		$	$ 1,321	1,494	$ 54,012	1
2	Licensed Speech and Language Development Therapist	L 10a, C 3	hrs		18	872		18	872	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a, C 1	1062 hrs	37,240				1,062	37,240	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				48,155		48,155	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Other (specify): Radiology	L39, C 3 L39, C 3				9,156 409			9,156 409	13
14	TOTAL			$ 89,931	18	$ 10,437	$ 49,476	2,574	$ 149,844	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 119,206	$ 119,206	1
2	Cash-Patient Deposits	53,799	53,799	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 228,000)	1,306,512	1,306,512	3
4	Supply Inventory (priced at Cost)	31,760	31,760	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,985	1,985	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	62,524	62,524	8
9	Other(specify): See Schedule 17A	1,101,459	1,101,459	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,677,245	$ 2,677,245	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	327,507	327,507	13
14	Buildings, at Historical Cost	6,475,612	6,517,939	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,722,456	1,700,422	16
17	Accumulated Depreciation (book methods)	(5,595,804)	(5,538,766)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Schedule 17A	90,804	90,804	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,020,575	$ 3,097,906	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,697,820	$ 5,775,151	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,036	$ 224,036	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,799	53,799	28
29	Short-Term Notes Payable	235,000	235,000	29
30	Accrued Salaries Payable	318,636	318,636	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,065	6,065	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	182,813	182,813	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Fees Payable	42,926	42,926	36
37	See Schedule 17 A	41,645	41,645	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,104,920	$ 1,104,920	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,005,000	5,005,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PIP Payments and Clearing Account	28,661	28,661	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,033,661	$ 5,033,661	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,138,581	$ 6,138,581	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (440,761)	$ (363,430)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,697,820	$ 5,775,151	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

SCHEDULE 17A

MERCY HEALTH CARE AND REHABILITATION CENTER
FACILITY ID # 00025940
6/30/2001

Schedule XV - Line 9 Other Current Assets

	Operating	After Consolidation
Investments/Mortgage Fund	72,835	72,835
Debt Service Reserve Fund	579,486	579,486
Interest Fund	183,594	183,594
Sinking Fund	265,544	265,544
	1,101,459	1,101,459

Schedule XV - Line 23 Other Assets

Unamortized Loan costs	18,780	18,780
Unamortized Bond costs	72,024	72,024
	90,804	90,804

Schedule XV - Line 37 Other Current Liabilities

Resident Insurance Premium	6,739	6,739
Mercy Foundation	-	-
Advanced Billings	34,906	34,906
	41,645	41,645

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 15,051	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 15,051	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(455,811)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (455,811)	17
	B. Transfers (Itemize):		
18	**Rounding**	(1)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (440,761)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,395,583	1
2	Discounts and Allowances for all Levels	(1,688,178)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,707,405	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	219,889	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 219,889	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,619	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	79,120	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,227	19
20	Radiology and X-Ray	409	20
21	Other Medical Services	153,025	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 294,400	23
	D. Non-Operating Revenue		
24	Contributions	35,237	24
25	Interest and Other Investment Income***	74,441	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 109,678	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	86	28
28a	Vending Machine Income	3,319	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,405	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,334,777	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,639,207	31
32	Health Care	3,699,013	32
33	General Administration	1,609,928	33
	B. Capital Expense		
34	Ownership	607,073	34
	C. Ancillary Expense		
35	Special Cost Centers	93,564	35
36	Provider Participation Fee	141,803	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,790,588	40
41	**Income before Income Taxes (line 30 minus line 40)****	(455,811)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (455,811)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

MERCY HEALTH CARE AND REHABILITATION CENTER
FACILITY ID # 00025940
6/30/2001
SEE ACCOUNTANTS' COMPILATION REPORT

Schedule XVII - Line 28 Other Revenue

Miscellaneous Income	86
Vending Machine Income	
Welcomefest Income	
Total Line 28	86

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,332	1,636	$ 53,063	$ 32.43	1
2	Assistant Director of Nursing	1,704	2,007	42,506	21.18	2
3	Registered Nurses	23,285	27,083	572,430	21.14	3
4	Licensed Practical Nurses	39,226	43,604	774,214	17.76	4
5	Nurse Aides & Orderlies	90,136	101,412	918,823	9.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,556	2,556	89,931	35.18	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	2,080	25,323	12.17	9
10	Activity Assistants	7,082	7,997	58,296	7.29	10
11	Social Service Workers	4,258	4,824	71,530	14.83	11
12	Dietician	1,808	2,080	30,322	14.58	12
13	Food Service Supervisor	1,797	2,080	21,305	10.24	13
14	Head Cook	8,213	9,071	83,346	9.19	14
15	Cook Helpers/Assistants	25,440	28,179	225,668	8.01	15
16	Dishwashers					16
17	Maintenance Workers	8,363	9,110	116,532	12.79	17
18	Housekeepers	30,513	34,941	311,990	8.93	18
19	Laundry	16,671	18,851	153,504	8.14	19
20	Administrator	1,832	2,080	75,571	36.33	20
21	Assistant Administrator	1,656	2,080	62,978	30.28	21
22	Other Administrative					22
23	Office Manager	1,752	2,080	46,317	22.27	23
24	Clerical	16,636	19,173	218,934	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,714	5,287	39,463	7.46	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	604	624	10,106	16.20	33
34	TOTAL (lines 1 - 33)	291,462	328,835	$ 4,002,152 *	$ 12.17	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	246	$ 10,151	L 1, C 3	35
36	Medical Director	480	53,333	L 9, C 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	1,800	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,800	L 11, C 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Security Consultant	24	1,200	L 6, C 3	47
48					48
49	TOTAL (lines 35 - 48)	910	$ 68,284		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	154	$ 6,589	L 10, C 3	50
51	Licensed Practical Nurses	3,645	95,327	L 10, C 3	51
52	Nurse Aides	40,668	721,038	L 10, C 3	52
53	TOTAL (lines 50 - 52)	44,467	$ 822,954		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janice Podwika	Administrator	0%	$ 75,571
Caryn Moore	Asst. Administrator	0%	62,978
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 138,549

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Seyfarth , Shaw Attorneys	Legal	$ 82,741
Altschuler, Melvoin & Glasser LLP	Accounting	37,101
American Express Tax and		
Business Services	Consulting	22,053
Near North Insurance Brokerage	Insurance Consulting	4,500
Martin Boyer Company, Inc.	Unemployment Comp.	445
MetLife RetireSource Team	Benefit Plan Consulting	1,425
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 148,265
Disallowed legal Fees		(8,801)
TOTAL (agree to Schedule V, line 19, column 8)		139,464

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,200
Unemployment Compensation Insurance	(2,759)
FICA Taxes	303,145
Employee Health Insurance	406,564
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	44,163
Miscellaneous Payroll Deductions	(553)
Other Employee Benefits	4,419
TOTAL (agree to Schedule V, line 22, col.8)	$ 831,179

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,317
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	8,743
Miscellaneous Licenses	1,330
Miscellaneous Dues	400
Miscellaneous Subscriptions	1,497
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,287

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,706
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,706

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 Report Period Beginning: 7/01/00 Ending: 6/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercy Health Care Rehab Center # 0025940 **Report Period Beginning:** 7/01/00 **Ending:** 6/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $8,743**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5.97 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,962** Line **4**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **141,803**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,619**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **The audit is not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Mercy Health Care and Rehabilitation Center
Provider Number 00025940
July 1, 2000 - June 30, 2001

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule V, Line 25, Other Administration Staff Transportation:

VENDOR	DESCRIPTION	AMOUNT
Village Pantry	Gas	1,010.00
Surefire Auto & Truck Repair	Parts and Repairs	1,611.00
Glenwood Citgo	Gas	378.00
Sutton Ford	Parts and Repairs	578.00
TOTAL		3,577.00

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	360,641	39,501	12,461	412,603	0	412,603	0	412,603
2. Food Purchase	0	302,520	0	302,520	0	302,520	-5,938	296,582
3. Housekeeping	311,990	38,989	0	350,979	0	350,979	0	350,979
4. Laundry	153,504	74,143	0	227,647	0	227,647	0	227,647
5. Heat and Other Utilities	0	0	195,640	195,640	0	195,640	0	195,640
6. Maintenance	116,532	11,897	21,389	149,818	0	149,818	0	149,818
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	942,667	467,050	229,490	1,639,207	0	1,639,207	-5,938	1,633,269
9. Medical Director	0	0	53,333	53,333	0	53,333	0	53,333
10. Nursing & Medical Records	2,400,499	164,510	824,754	3,389,763	0	3,389,763	0	3,389,763
10a. Therapy	89,931	1,321	872	92,124	0	92,124	0	92,124
11. Activities	83,619	4,595	2,983	91,197	0	91,197	0	91,197
12. Social Services	71,530	1,066	0	72,596	0	72,596	0	72,596
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,645,579	171,492	881,942	3,699,013	0	3,699,013	0	3,699,013
17. Administrative	138,549	0	0	138,549	0	138,549	0	138,549
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	148,265	148,265	0	148,265	-8,801	139,464
20. Fees, Subscriptions & Promotion	0	0	14,377	14,377	0	14,377	-1,090	13,287
21. Clerical & General Office	275,357	15,189	51,939	342,485	0	342,485	-10,192	332,293
22. Employee Benefits & Payroll	0	0	831,179	831,179	0	831,179	0	831,179
23. Inservice Training & Education	0	0	846	846	0	846	0	846
24. Travel and Seminar	0	0	1,706	1,706	0	1,706	0	1,706
25. Other Admin. Staff Trans	0	0	3,577	3,577	0	3,577	0	3,577
26. Insurance-Prop.Liab.Malpractice	0	0	128,944	128,944	0	128,944	0	128,944
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	413,906	15,189	1,180,833	1,609,928	0	1,609,928	-20,083	1,589,845
29. Total General Administrative	4,002,152	653,731	2,292,265	6,948,148	0	6,948,148	-26,021	6,922,127
30. Depreciation	0	0	204,983	204,983	0	204,983	5,410	210,393
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	386,242	386,242	0	386,242	-74,441	311,801
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	15,848	15,848	0	15,848	0	15,848
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	607,073	607,073	0	607,073	-69,031	538,042
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	48,155	9,565	57,720	0	57,720	0	57,720
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	141,803	141,803	0	141,803	0	141,803
43. Other (specify):*	0	0	35,844	35,844	0	35,844	-35,844	0
44. Total Special Cost Ce	0	48,155	187,212	235,367	0	235,367	-35,844	199,523
45. Grand Total	4,002,152	701,886	3,086,550	7,790,588	0	7,790,588	-130,896	7,659,692

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	119,206	119,206
2. Cash - Patient Deposits	53,799	53,799
3. Accounts & Notes Recievable	1,306,512	1,306,512
4. Supply Inventory	31,760	31,760
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,985	1,985
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	62,524	62,524
9. Other (specify):	1,101,459	1,101,459
10. Total current assets	2,677,245	2,677,245
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	327,507	327,507
14. Buildings, at Historical Cost	6,475,612	6,517,939
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,722,456	1,700,422
17. Accumulated Depreciation (book methods)	-5,595,804	-5,538,766
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	90,804	90,804
24. Total Long-Term Assets	3,020,575	3,097,906
25. Total Assets	5,697,820	5,775,151
CURRENT LIABILITIES		
26. Accounts Payable	224,036	224,036
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	53,799	53,799
29. Short-Term Notes Payable	235,000	235,000
30. Accrued Salaries Payable	318,636	318,636
31. Accrued Taxes Payable	6,065	6,065
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	182,813	182,813
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	42,926	42,926
37. Other Current Liabilities (specify):	41,645	41,645
38. Total Current Liabilities	1,104,920	1,104,920
LONG TERM LIABILITES		
39.Long-Term Notes Payable	5,005,000	5,005,000
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	28,661	28,661
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	5,033,661	5,033,661
46.Total Liabilities	6,138,581	6,138,581
47.Total Equity	-440,761	-363,430
48.Total Liabilities and Equity	5,697,820	5,775,151

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,395,583
2. Discounts and Allowances for all Levels	-1,688,178
Subtotal - Inpatient Care	6,707,405
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	219,889
7. Oxygen	0
Subtotal - Anciliary Revenue	219,889
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,619
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	79,120
18. Sale of Supplies to Non-Patients	0
19. Laboratory	59,227
20. Radiologyand X-Ray	409
21. Other Medical Services	153,025
22. Laundry	0
Subtotal - Other Operating Revenue	294,400
24. Contributions	35,237
25. Interest and Other Investments Income	74,441
Subtotal - Non-Operating Revenue	109,678
27. Other Revenue (specify):	86
28. Other Revenue (specify):	3,319
Subtotal - Other Revenue	3,405
30. Total Revenue	7,334,777
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	4,585,161
42. Income Taxes	0
43. Net Income or Loss for the Year	4,585,161

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Mercy Health Care Reha** **03:32 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-130,896	equal to	-130,896	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	311,801	equal to	311,801	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	210,393	equal to	210,393	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	15,848	equal to	15,848	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	89,931	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	92,124	equal to	92,124	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	49,476	equal to	49,476	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,639,207	equal to	1,639,207	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,699,013	equal to	3,699,013	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,609,928	equal to	1,609,928	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	607,073	equal to	607,073	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	93,564	equal to	93,564	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	141,803	equal to	141,803	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,400,499	equal to	2,400,499	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	89,931	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	83,619	equal to	83,619	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	71,530	equal to	71,530	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	360,641	equal to	360,641	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	116,532	equal to	116,532	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	311,990	equal to	311,990	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	153,504	equal to	153,504	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	138,549	equal to	138,549	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	265,251	equal to	275,357	-10,106	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,002,152	equal to	4,002,152	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	10,151	< or = to	12,461	-2,310	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	53,333	< or = to	53,333	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	824,754	< or = to	824,754	0	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,800	< or = to	2,983	-1,183	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	138,549	equal to	138,549	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	148,265	equal to	148,265	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	831,179	equal to	831,179	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,287	equal to	13,287	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,706	equal to	1,706	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	141,803	equal to	141,803	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,985	equal to	2,288	-303	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,240,000	equal to	5,240,000	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	327,507	equal to	327,507	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,517,939	equal to	6,517,939	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,700,422	equal to	1,700,422	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,538,766	equal to	5,538,766	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-440,761	equal to	-440,761	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-455,811	equal to	-455,811	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,697,820	equal to	5,697,820	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1